ENVIRONMENTAL AND PUBLIC PROTECTION CABINET

DEPARTMENT OF LABOR

OFFICE OF WORKERS' CLAIMS

(Amendment)

803 KAR 25:110. Workers' compensation managed health care plans.

RELATES TO: KRS Chapter 342

STATUTORY AUTHORITY: KRS 342.020, 342.035, 342.735

NECESSITY, FUNCTION, AND CONFORMITY: The purpose of this administrative regulation is to establish procedures and standards for certification of workers' compensation managed health care system health care plans pursuant to KRS 342.020. The function of a managed care plan is to assure that quality medical care will be delivered to the injured employee at a reasonable cost so as to expedite the injured employee's recovery and facilitate return to work.

Section 1. Definitions. (1) "Executive Director" is defined by KRS 342.0011(9) [~~Commissioner" means the Commissioner of the Department of Workers' Claims~~].

(2) "Emergency care" means those medical services required for the immediate diagnosis or treatment of a medical condition that if not immediately diagnosed or treated could lead to serious physical or mental disability or death, or medical services that are immediately necessary to alleviate severe pain.

"Emergency care" does not include follow-up care, except when immediate care is required to avoid serious disability or death.

(3) "Gatekeeper physician" means any qualified physician, as defined in KRS 342.0011, acting within the scope of his or her license who has been specifically designated by a managed health care system to provide primary care to a patient and to [~~and designated by a managed care plan as a "gatekeeper" empowered to~~] make referrals of patients to other providers for specialized care or diagnostic services.

(4) "Managed health care system" means a health care network that utilizes gatekeeper physicians, performs utilization review, and does medical bill audits.

(5) "Managed care plan" means a written plan describing the operations of a managed health care system.

(6) "Provider" means any person or entity licensed, certified, or registered to provide medical services.

(7) "Revocation" means the termination of a managed health care plan certificate to provide services under the Kentucky Workers' Compensation Act prior to expiration of the certificate.

(8) "Service area" means a geographic area consisting of a county or group of counties of which no county shall be subdivided.

Section 2. Certification Process. (1)(a) All managed care plans shall be certified by the executive director [~~commissioner~~].

(b) A [~~Any~~] managed health care system may apply to have a plan or plans certified by the executive director [~~commissioner~~].

(c) Managed health care systems may operate one (1) or more plans.

(2) An application [~~Applications~~] for initial certification and renewal shall be submitted[~~, in triplicate,~~] in a form acceptable to the executive director [~~commissioner~~] and shall contain the following information:

(a) System identification: [~~-~~]

1. System name and address, [~~-~~]

2. Date and state of incorporation, [~~-~~]

3. Name, address, and phone number of each corporate officer, [~~and~~] director, and [~~of the person who will be the~~] day-to-day plan administrator, [~~-~~]

4. Name and address of each owner of more than five (5) percent of the stock or controlling interest in the entity, [~~-~~]

5. Name, address, and phone number of the medical director, who shall be a doctor of medicine (M.D.) or doctor of osteopathic medicine (D.O.) [~~medical doctor (M.D. physician)~~] and who shall oversee and monitor compliance with the quality care, utilization review and credentialing provisions of the managed care plan, [~~-~~]

6. Name, company name, address, and phone number of the case manager who shall be qualified as either a certified case manager, certified rehabilitation counselor, certified insurance rehabilitation specialist, or certified rehabilitation registered nurse who shall oversee and monitor case management provisions of the managed care plan, [~~-~~]

7. Description of the system's organizational structure: [~~-~~]

(b) System qualifications: [~~-~~]

1. Description and map of the system's service area, [~~-~~]

2. Name, address, phone number, and specialty of all participating providers separated by county,

3. A list of [~~separately identifying~~] those providers who shall serve as gatekeeper physicians, including [~~. The list of available gatekeeper physicians shall include~~] an appropriate choice of the various [~~different~~] types of physicians described in KRS 342.0011.

4. The system shall provide assurance that all licensing, registration, or certification requirements have been met and are current for the providers to practice in Kentucky (or border states wherein the provider practices) and that each participating provider shall maintain in full force and effect a professional malpractice policy with limits of no less than $500,000 [~~$250,000~~] for an occurrence of professional negligence.

5. [~~3.~~] A copy [~~specimen~~] of the agreement that each class of medical provider shall execute to participate in the system.

6.a. [~~4.~~] A copy [~~Specimens~~] of the materials which the system shall provide to workers setting forth the grievance procedure and form, the requirements and restrictions of the system, the list of providers to be used by workers, and the means of accessing services and treatment within and outside of the service area.

b. The applicant shall detail the time and means by which the materials shall be delivered to employees and employers.

7. [~~5.~~] A copy [~~Specimens~~] of materials directed at management employees informing supervisors of the necessity of channeling injured workers to the

managed care plan providers and giving immediate notice to the employer, insurance carrier, and plan of the occurrence of an injury.

Section 3. Financial Ability. (1) Each managed health care system shall demonstrate to the executive director [~~commissioner~~] that it has sufficient financial resources and professional expertise to perform all of the necessary functions of a managed health care system and managed care plan[~~. Each managed health care system requesting certification shall demonstrate such resources and ability to the commissioner~~] by the following:

(a) [~~(1)~~] In the event the applicant has previously provided managed care or other similar medical and administrative services in the Commonwealth of Kentucky, the applicant shall provide the following:

1. a summary and description of the administrative and medical services provided, and

2. [~~together with~~] a list of representative entities for which managed care related administrative or medical services have been provided; and

(b) 1. [~~(2)~~] In the event the applicant has not previously provided services related to the delivery of managed care in the Commonwealth, the executive director [~~commissioner~~] shall require, prior to certification, that the applicant post either a performance bond or cash surety deposit in an amount of $500,000 with the office of the executive director [~~commissioner~~] (by use of Form MC-1 or MC-2) to demonstrate sufficient financial resources to provide all of the administrative and medical services required to be performed under a managed care plan; [~~.~~]

2. The bond or cash surety shall be released by the executive director [~~commissioner~~] sixty (60) days after the managed health care system demonstrates to the executive director [~~commissioner~~] that all of its arrangements for rendering workers' compensation managed care services in the Commonwealth have been terminated; and [~~.~~]

3. If managed care system demonstrates three (3) consecutive years of good performance, the executive director may release the bond or cash surety.

(c) [~~(3)~~] If the applicant has an audited financial statement addressing any of its prior operations for the preceding year, a copy of the applicant's most recent audited financial statement shall be submitted to the executive director [~~commissioner~~].

Section 4. Plan Qualifications. (1) A copy of the managed care plan shall be submitted[~~, in triplicate,~~] with the application which [~~and~~] shall comply with the requirements in this section of this administrative regulation. [~~demonstrate:~~]

(2) A plan shall provide assurance [~~(1) Assurance~~] of access to quality medical services in a prompt, effective manner for employees of employers using the managed care plan.

(3) The plan shall: (a) Offer an adequate number of health care providers including gatekeeper, specialty and subspecialty physicians, and general and specialty hospitals to afford employees reasonable choice and convenient geographic accessibility to all categories of licensed care, and

(b) Provide a complete list of the health care providers to injured employees.

(4) The employee shall choose a gatekeeper physician when it becomes apparent that continuing care is required for an injury or disease compensable under KRS Chapter 342.

(5) Employers [~~(2) That employers~~] or insurers may contract with multiple managed health care systems in order to maximize access for their employees.

(6) An employee [~~(3) That employees~~] may access providers who are not participating plan providers:

(a) For emergency care as defined in Section 1 of this administrative regulation;

(b) When the employee is referred by a gatekeeper physician outside the managed care plan for medical services [~~by a gatekeeper physician~~];

(c) When authorized treatment is unavailable through the managed care plan; or

(d) To obtain a second opinion when a managed care plan physician recommends surgery.

(7) The plan shall have mechanisms [~~(4) Mechanisms~~] to ensure continuity of care upon termination of contracts between the managed health care system, the employer, and/or participating providers.

(8) The plan shall have mechanisms [~~(5) Mechanisms~~] for utilization review which shall prevent inappropriate, excessive, or medically unnecessary medical services and including:

(a) 1. Treatment standards upon which utilization review decisions shall be based (including low back symptoms and injuries to the upper extremities and

knees) assuring quality care in accordance with prevailing standards in the medical community of which the plan provider is a member.

2. The standards shall conform to any practice parameters or guidelines for clinical practice adopted by the executive director [~~commissioner~~];

(b) Mechanisms requiring periodic review to determine that continued treatment of an injured employee is reasonable, appropriate, and medically necessary[~~, and that treatment plans required by Section 12 of this administrative regulation have been timely prepared~~];

(c) Assurance that the managed health care system is conducting utilization review in accordance with the standards set forth in 803 KAR 25:190; and

(d) Adequate procedures for credentialing providers and evaluating the quality and cost effectiveness of services delivered under the plan.

(9) The plan shall have provisions [~~(6) Provisions~~] for employer or carrier audit of the managed health care system's operations and the financial arrangements between the system and its providers.

(10) [~~(7)~~] A grievance procedure meeting the requirements of Section 10 of this administrative regulation shall be in the plan.

(11) The plan shall demonstrate effective [~~(8) Effective~~] methods of informing employees, employers, and medical providers of the services provided by the plan and requirements imposed by the plan, including a twenty-four (24) hour toll free phone number by which information may be obtained concerning plan operations, after-office-hours care, and twenty-four (24) hour access to emergency care.

(12)(a) [~~(9)~~] A system to provide authorization numbers to medical providers and health facilities where preauthorization or continued stay review is required by the plan.

(b) The authorization numbers shall be recorded in the treatment authorization code section of the appropriate billing forms.

(13)(a) The plan shall demonstrate aggressive [~~(10) Aggressive~~] case management by either a certified case manager, certified rehabilitation counselor, certified insurance rehabilitation specialist, or a certified rehabilitation registered nurse to coordinate the delivery of health services and return to work policies; promote an appropriate, prompt return to work; and facilitate communication between the employee, employer, and health care providers.

(b) The plan shall describe the circumstances under which injured employees shall be subject to case management and the services to be provided.

(14) [~~(11)~~] A spreadsheet shall [~~notice on Form MC-3 to~~] be mailed or emailed to the Office [~~Department~~] of Workers' Claims for entry into the Office's [~~Department's~~] computer database that indicates the employers who have become associated with a managed care plan which shall include: [~~.~~]

(a) Name and address of employer or carrier;

(b) Date of enrollment; and

(c) Date of termination, if applicable.

Section 5. Plan Certification. (1) The executive director [~~commissioner~~] shall notify the applicant in writing of the determination made upon the application for

certification or modification thereof, within sixty (60) days of receipt of a complete application.

(2) A certificate shall be valid for a period of two (2) years and only for the service area and managed care plan or plans specified by the executive director [~~commissioner~~].

(3) Upon written request made at least sixty (60) days prior to expiration of the current certificate, the executive director [~~commissioner~~] may recertify a plan for additional successive two (2) year periods.

(4) Geographical areas may be added upon the filing of a supplemental application demonstrating the managed health care system's ability to serve the expanded area.

(5)(a) [~~(3)~~] If an application does not meet the requirements for certification or expansion, the executive director [~~commissioner~~] shall notify the applicant in writing and specify those items deemed deficient.

(b) The applicant is granted thirty (30) days from the date of notice of the deficiency by the executive director [~~commissioner~~] to correct deficiencies through an amended application.

(6)(a) [~~(4)~~] Certifications of a managed care plan are not transferable.

(b) A new application for certification shall [~~must~~] be filed when fifty (50) percent or more of the ownership or controlling interest of a system has been transferred.

Section 6. Plan Modifications. (1) A managed health care system which either implements or experiences material variations as to any matter set forth in the

original application or managed care plan shall obtain approval for the modification by filing a request for modification with the executive director [~~commissioner~~].

(2) Intended variations shall not be implemented until approved by the executive director [~~commissioner~~].

(3) A modification outside the control of the system shall be filed with the commissioner within fifteen (15) days of its occurrence.

(4)(a) Within fifteen (15) days of entering into an agreement with an employer or insurer to provide workers' compensation managed care services, the managed health care system shall submit notification thereof to the executive director [~~commissioner~~].

(b) The notification shall identify the employer or employers with whom the managed health care system has contracted and the certified managed care plan applicable to that employer.

(c) Notification shall be deemed approved unless disapproved by the executive director [~~commissioner~~] in writing within fifteen (15) days of filing.

(d) The system shall promptly furnish any information deemed necessary by the executive director [~~commissioner~~] to review the notice.

(e) When an employer or insurer terminates a contract with a managed health care system, the managed health care system shall file notification with the executive director [~~commissioner~~] within fifteen (15) days of the occurrence, indicating the employers for whom managed care services have been terminated and the effective date of the termination.

Section 7. Suspension or Revocation of Certification. (1) The certification of a managed care plan by the executive director [~~commissioner~~] may be suspended or revoked if:

(a) Service is not being provided: 1. according to the terms of the certified managed care plan,

2. [~~or~~] in accordance with prevailing treatment standards, or

3. in accordance with treatment standards or practice parameters adopted by the executive director [~~commissioner~~];

(b) The plan for providing services or the contract with the insurer or health care provider fails to meet the requirements of KRS Chapter 342 or this administrative regulation;

(c) Any material false or misleading information is intentionally submitted by the managed health care system or participating provider to the executive director [~~commissioner~~], the employer, or the insurer; or

(d) The managed health care system knowingly or negligently utilizes a health care provider whose license, registration, or certification has been suspended or revoked, or who is otherwise ineligible to provide treatment of the type rendered to an injured employee.

(2) The executive director [~~commissioner~~] may investigate the operations of certified managed health care systems at any time and the system and its providers shall cooperate in any investigation by the executive director [~~commissioner~~].

(3)(a) If [~~Should~~] the executive director determines [~~commissioner believe~~] that grounds for termination or suspension of a managed care plan certification exists [~~exist~~], written notice setting forth those grounds shall be mailed to the managed care system.

(b) The system is granted fifteen (15) days from the date of the notice in which to file written response.

(c) Thereafter, the executive director [~~commissioner~~] shall render a written decision by which the certification of the plan may be terminated, suspended, or conditionally continued to permit the correction of deficiencies directed.

Section 8. Appeal of Executive Director's [~~Commissioner's~~] Action. Any managed health care system may seek review in the Franklin Circuit Court within thirty (30) days of the date of the executive director's [~~commissioner's~~] final decision concerning its managed care plan.

Section 9. Coverage. (1) All employees of an employer for whom a managed care plan has been approved by the executive director [~~commissioner~~] shall obtain medical services compensable under KRS Chapter 342 from the certified managed care plan of the employer with the following exceptions: (a) [~~, except~~] for those injuries or diseases for which continuing treatment was initiated prior to the date the managed care plan for the employer was approved, the employee may continue with its current treating physician; [~~.~~]

(b) [~~However,~~] when an employee under continuing care changes the designation of treating physician, the employee's provider choice shall be limited to

providers under the certified managed care plan and medical services thereafter shall be obtained pursuant to the managed care plan.

(c) [~~(2)~~] If initial emergency care following a compensable injury is rendered by a medical provider outside the managed health care plan, the injured worker may remain under the care of that provider so long as the provider complies with utilization review, reporting standards, and quality assurance mechanisms prescribed by the employer's managed care plan.

(d) Reimbursement of these nonplan providers shall be at the level prescribed by applicable workers' compensation fee schedules.

Section 10. Grievance Procedure. (1) Each workers' compensation managed care plan shall contain an expeditious, informal grievance procedure to resolve disputes by employees and providers relative to the rendition of medical services.

(2) A detailed description of the employee grievance procedure shall be included in informational materials provided to employees and a detailed description of the provider grievance procedure shall be included in all provider contracts.

(3) [~~(2)~~] The grievance procedure shall meet the following requirements:

(a) Notice. A grievance is made when a written complaint or written request is delivered by the employee or provider to the managed health care system setting forth the nature of the complaint and remedial action requested.

(b) Time frame to file grievance. The employee or provider shall file a grievance within thirty (30) days of the occurrence of the event giving rise to the dispute.

(c) Resolution. The managed health care system shall render a written decision upon a grievance within thirty (30) days of receipt by the managed health care system of the grievance.

(d) Arbitration. 1. Managed care plans may provide for alternate means of dispute resolution including arbitration and mediation.

2. In that event final resolution of a grievance shall not be subject to the time constraints set forth in paragraph (c) of this subsection.

3. In all cases, resolution mechanisms shall be expeditious and where treatment matters are at issue reflect the need for prompt resolution.

(4) [~~(3)~~] Record of grievance proceedings. The managed health care system shall maintain records for two (2) years of each formal grievance to include the following:

(a) A description of the grievance;

(b) the employee's name and address;

(c) names and addresses of the health care providers relevant to the grievance;

(d) [~~and~~] the managed health care system's and employer's name and address; and

(e) [~~(b)~~] A description of the managed health care system's findings, conclusions, and disposition of the grievance.

(5) [~~(4)~~] Appeal. (a) Any employee or provider dissatisfied with the managed health care system's resolution of a grievance may apply for review by an

administrative law judge by filing a request for resolution within thirty (30) days of the date of the system's final decision.

(b) Upon review by an administrative law judge the movant shall be required to prove that the system's final decision is unreasonable or otherwise fails to conform with KRS Chapter 342.

Section 11. Reporting. Each managed health care system having a certified managed care plan shall submit: (1) an annual [~~a~~] report to the executive director [~~commissioner annually~~] on or before April 15 containing the following information for the previous year:

(a) [~~(1)~~] Number of employees treated by the managed care plan.

(b) Number of employers and employees covered by the managed care plan.

(c) [~~(2) Number of work-related injuries or diseases by ICD-9 code treated under the managed care plan in the preceding year.~~

~~(3) Breakdown by ICD-9 codes of injuries and diseases treated.~~

~~(4) Total medical costs.~~

~~(5) Average medical cost per injured employee by type of injury.~~

~~(6) Average medical cost per diseased employee by type of disease.~~

~~(7) Breakdown of medical cost elements as to type of physician utilized, hospital costs, drug costs, and other costs.~~

~~(8)~~] Number of grievances filed, and summary of action taken.

[~~(9) Number of days by type of injury and disease for which an employee has been released from work.~~]

(2) On or before April 15 and October 15 of each year, a copy of the provider directory of participating medical providers shall be provided to the executive director.

Section 12. Treatment Plans. (1) Those sections of 803 KAR 25:096 concerning treatment plans [~~and use of the Form 113~~] shall to the extent possible, apply to managed care plans.

(2) Each managed health care system shall retain treatment plans and make them available to the employee, employer, Special Fund, Uninsured Employers' Fund, administrative law judges, or attorneys representing any of the parties, upon request.

Section 13. Provider Verification. (1) Each employer which provides medical services through a managed care plan will provide to the injured employee a written certification of workers' compensation managed care coverage as soon as practicable following notice of a compensable injury or disease requiring continuing medical services.

(2) The verification shall contain the following information:

(a) Employer name, address, and phone number;

(b) Name and telephone number of the managed health care system to be contacted; and

(c) Employee name and Social Security number.

(3) [~~(2)~~] Possession of such verification shall [~~is~~] not [~~to~~] be construed as authorization for medical service or payment.

Section 14. Incorporation by Reference.

(1) The following material is incorporated by reference:

(a) Form MC-1, and

(b) Form MC-2.

(2) This material may be inspected, copied or obtained, subject to applicable copyright law, at the Office of Workers' Claims, 657 Chamberlin Avenue, Frankfort, Kentucky 40601, Monday through Friday, 8:00 a.m. to 4:30 p.m. [~~Forms. (1) One (1) copy of Forms MC-1, MC-2, and MC-3 is filed herewith and incorporated by reference.~~

~~(2) Information and material is available for public inspection and copying at main, regional, and branch offices of the agency:~~

~~(a) Frankfort - Prevention Park, 657 To Be Announced Avenue, Frankfort, Kentucky 40601;~~

~~(b) Louisville - Fourth Floor - The Meyer Building 624 West Main Street, Louisville, Kentucky 40202;~~

~~(c) Lexington - 950 National City Plaza, Lexington, Kentucky 40507;~~

~~(d) Paducah - 220B North 8th Street, Paducah, Kentucky 42001;~~

~~(e) Pikeville - The Justice Building, 3rd Floor, 314-316 Second Street, Pikeville, Kentucky 41501.~~

~~(3) Office hours of each office are 9 a.m. to 4 p.m., Monday through Friday, inclusive, for this purpose.~~]

William P. Emrick, Executive Director
Office of Workers' Claims

8-3-2007
Date

A public hearing on this administrative regulation shall be held on September 21, 2007, at 10:00 a.m. (EST) at the offices of the Office of Workers' Claims, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by September 14, 2007, five workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until October 1, 2007. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Carla H. Montgomery, General Counsel
Office of Worker's Claims
Prevention Park
657 Chamberlin Avenue
Frankfort, Kentucky 40601
Telephone Number: (502) 564-5550, Ext. 4464
Fax Number: (502) 564-0681